

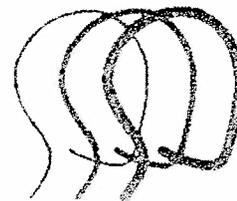
2011 Achievable Goal for
Michigan's OIF/OEF Veterans

Get 80% of all eligible
OIF/OEF post deployed
Michigan Army & Air
National Guard members
registered with the VA.

Brain Injury Association Of Michigan's
Veterans Program



“An introduction to the issues facing our post-deployed troops and the scope and outreach of your BLAMI Veterans Program”



**BRAIN INJURY
ASSOCIATION**
OF MICHIGAN

Presentation Outline

- Issues facing combatants
- Invisible Wounds
- Traumatic Brain Injury
- Brain Injury Association of Michigan (BIAMI)
- BIAMI Veterans Program
- Automated Neuro-cognitive Assessment Matrix (ANAM)
- Tricare/Medicare “Barriers to Treatment”
- Veterans Outreach Programs

Post-Deployment Issues

the role of “Invisible Wounds”

- SUICIDE
- UNEMPLOYMENT
- DIVORCE
- HOMELESSNESS
- INCARCERATION

About “Invisible Wounds”

Traumatic Brain Injury (TBI)

and

Post Traumatic Stress Disorder (PTSD)

Traumatic Brain Injury

The “Signature Wound” of the War on Terror

- **Caused by:**

- Improvised Explosive Devices
- Vehicle Accidents & Falls
- Mortars, Grenades and Mines
- Bullets



- Called the “*Invisible Wound*” because a very serious injury can be sustained without visible indicators.

TBI Symptoms

- Headache
- Irritability
- Memory Loss
- More Emotional
- Trouble Sleeping
- Numbness / Tingling
- Dazed or Stunned
- Forget Recent Conversations
- Difficulty Concentrating
- Mood Changes
- Nervousness
- Balance Problems
- Sensitivity to Light
- Fatigue
- Drowsiness
- Sleep More or Less
- Difficulty Making Decisions
- Respond to Questions Slowly
- Ringing in the Ears
- Mentally Foggy
- Nausea / Vomiting
- Feeling Slowed Down
- Sadness
- Dizziness

BIAMI Veterans Program Summary

- The BIAMI Veterans Program has focused its efforts on more proactive and preventative programs in lieu of reactive programs.
- The issues facing post deployed combatants are not fully being addressed and will take a full on effort by the legislative leadership, the DOD, the VA, and private sector efforts to include healthcare, faith based, and non-profit organizations.

Post Deployment Troops in Crisis

WASHINGTON, July 2010 /PRNewswire-USNewswire –

American troops returning from Iraq and Afghanistan cannot depend solely on the Departments of Defense (DoD) and Veterans Affairs (VA) for mental healthcare - even though the civilian mental health care system is in crisis, according to the annual convention of the National Alliance on Mental Illness.

Post Deployment Troops in Crisis (cont'd)

• *"The VA and DoD can't do it alone. We need to rely on community providers,"* declared Jon Towers, senior policy advisor on the U.S. Senate Committee on Veterans Affairs at a symposium broadcast live on C-SPAN.

• In the opening speech at the 2010 NAMI Convention, U.S. Representative Patrick Kennedy warned, *"Every day in America, our military veterans are being held behind enemy lines"* because of the nation's *"Byzantine mental health system."*

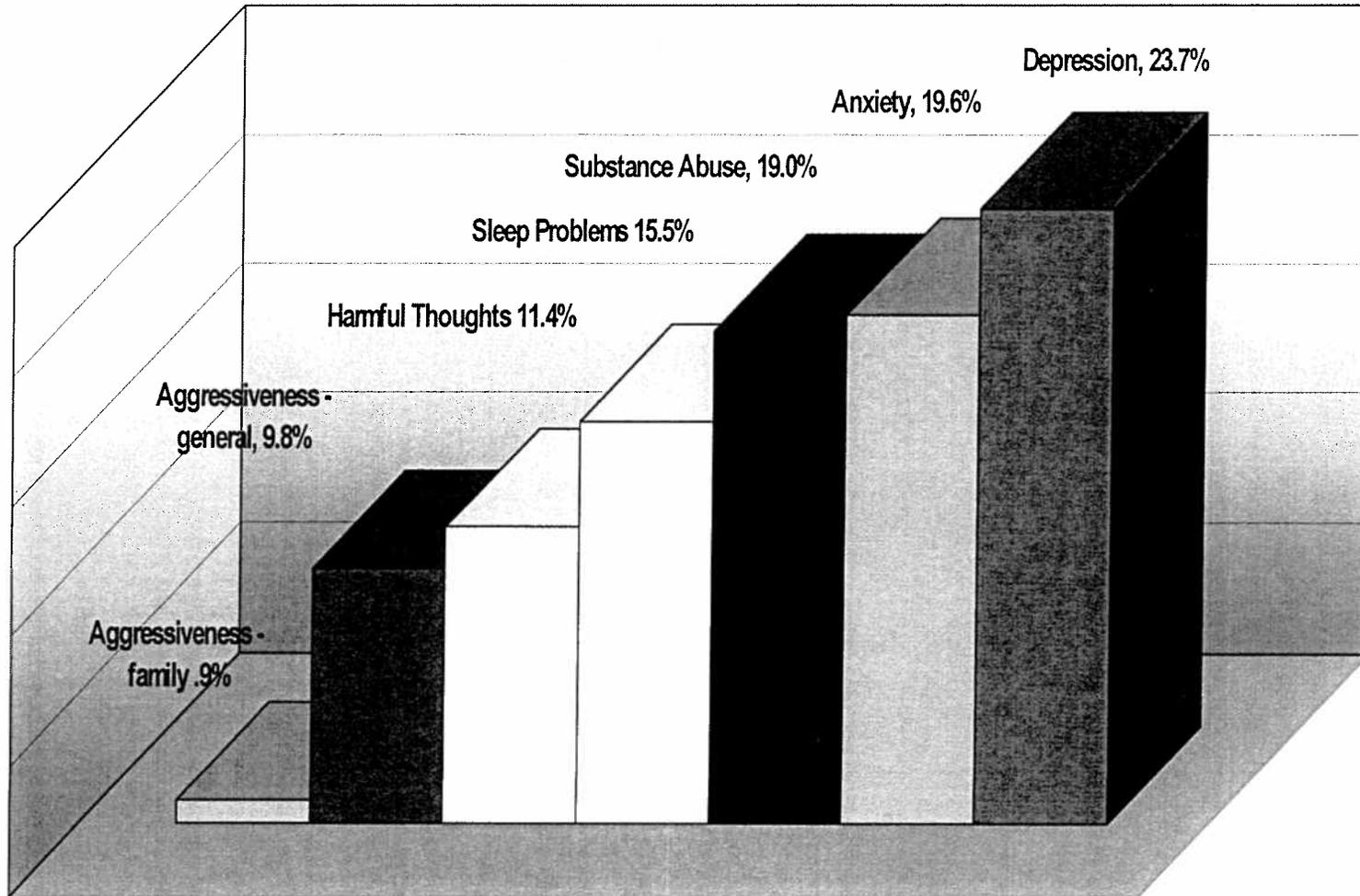
Substance Abuse Mental Health Services Administration (SAMHSA) Recommendations:

“Prevention works, treatment is effective, and people recover from mental and substance use disorders.”

- SAMHSA recommends the creation or expansion of the delivery of screening, treatment and support to active duty, guard and reserve members to recover from mental illness including trauma related disorders and to their families to build resiliency and support recovery.
- Behavioral health services improve health status and reduce health care and other costs to society.

Of Veterans seen in both Group or Individual Therapy, how many were diagnosed with one or more of the following conditions? (N=316)

(MN Community Mental Health Programs Survey, April 2010)



□ Aggressiveness - family ■ Aggressiveness - general □ Harmful Thoughts □ Sleep Problems ■ Substance Abuse □ Anxiety ■ Depression

BIAMI Veterans Program

Position Statement

“Only time will prove that the cost of paying for incarceration, homelessness, and social and community support programs will exceed those costs associated with providing comprehensive “Invisible Wounds” treatment programs. That is not even considering the quality of life and lost opportunities for our returning combatants and their families. Our military families will bare the future burdens of our failed rehabilitation programs today.”

- Major Rick Briggs, U.S.A.F., (Ret), July 13th, 2010



BRAIN INJURY ASSOCIATION OF MICHIGAN

The mission of the Brain Injury Association of Michigan (BIAMI) is to enhance the lives of those affected by brain injury through education, advocacy, research, and local support groups; and to reduce the incidence of brain injury through prevention.

Incorporated in 1981, the BIAMI was one of the first state associations chartered by the Brain Injury Association of America. Today, thanks to Michigan's system of automotive no-fault insurance and other factors, our state is fortunate to have one of the country's largest and most comprehensive statewide networks of research, treatment and support services for people with brain injuries and their families.

Commission on Accreditation of Rehabilitation Facilities (CARF)
Accredited Brain Injury Providers In Michigan
April 30, 2010

Provider Parent Company	Parent Company	Home & Community Based Rehab	Residential Rehabilitation	Outpatient Rehabilitation	Vocational Services	Inpatient Hospital	Long Term Residential	Skilled Nursing
Ann Arbor Rehabilitation Centers Inc	1	5		1				
Borgess Medical Center	1					1		
Childrens Hospital	1			2				
Coach House Rehabilitation Center	1	2	3	1			3	
Covenant Health Care	1					1		
Eisenhower Center	1		3		3		3	
Irvine Head Injury	1		2	1			2	
Hope Network Rehabilitation Services	1	3	4	3	2		7	
Learning Services Corp	1						1	
Lighthouse Inc	1		13	2	2		13	
Mary Free Bed Rehabilitation	1			1		1		
Munson Medical - Memory & Attention Tng Cntr	1	1		1	1			
Origami Brain Injury Rehabilitation Center	1	1	1	1	1		1	
Rainbow Rehabilitation Center	1	2	34	3	3		34	
Rehab With out Walls	1	1						
Rehabilitation Institute of Michigan	1			1		1		
Spectrum Health Continuing Care	1	1	1				1	1
Special Tree Rehabilitation	1		17	5			17	
TOTAL	18	16	78	22	12	4	82	1
National Totals		49	330	145	51	115	333	5
Michigan Percentage of National Total		33%	24%	15%	24%	3%	25%	20%

The BIAMI Veterans Program

“Outreach Programs”

- HRSA Grant Goals & Objectives
- Director - Operation Never Forgotten “Invisible Wounds” National Awareness Campaign
- Vice Chair - Michigan DNRE Disability Accessibility Advisory Council
- Communications Co-Chair - TBI-Resource Optimization Center Advisory Council, Bethesda, MD
- Advisor / Trainer - Faith Based Veterans Task Force Initiative
- Advisor / Trainer - Police & Veterans Task Force “Invisible Wounds” Training Program
- Veteran Recreational Outreach Programs
- Effecting Change on the Tricare – Health Net System, the DOD’s TBI Baseline Testing Program, and TBI rehabilitation programs in both the VA and DOD.

TBI-Resource Optimization Center

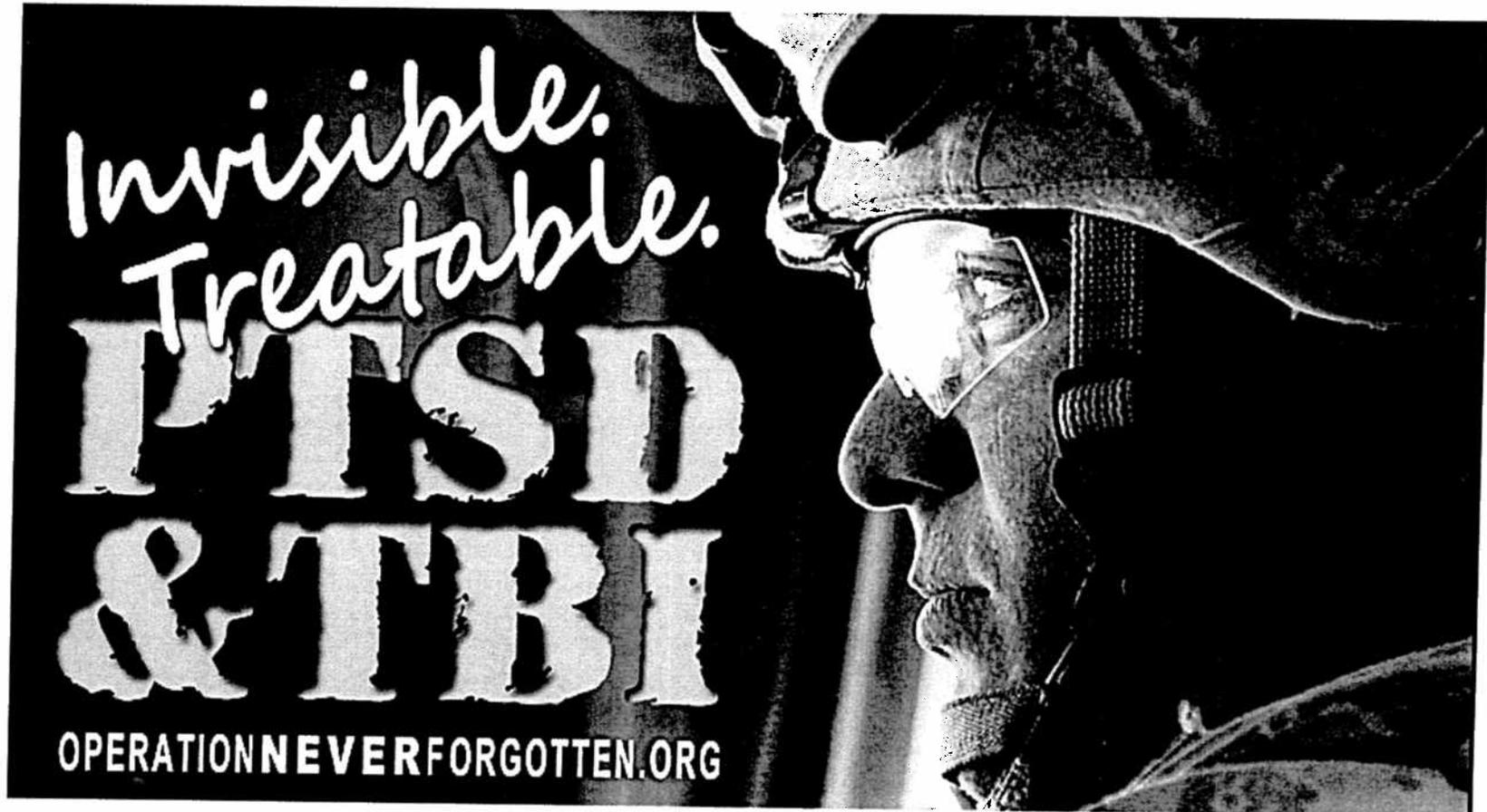
Automated Neurocognitive Assessment

- The 2008 National Defense Authorization Act mandated pre-deployment and post-deployment neurocognitive assessments for all U.S. military members.
- The Department of Defense has collect 600,000 pre-deployment baselines.
- Pre-deployment assessments results are available in DOD for comparison with assessments collected after deployment, injury, illness, exposure, etc.

Tricare/Medicare Barriers

- Healthcare providers that specialize in TBI neuro-cognitive rehabilitation can not be Medicare providers because neuro-cognitive rehabilitation is not Medicare approved.
- Providers that are not Medicare approved and provide Medicare services can not become Tricare approved vendors.

ONF Invisible Wounds Campaign

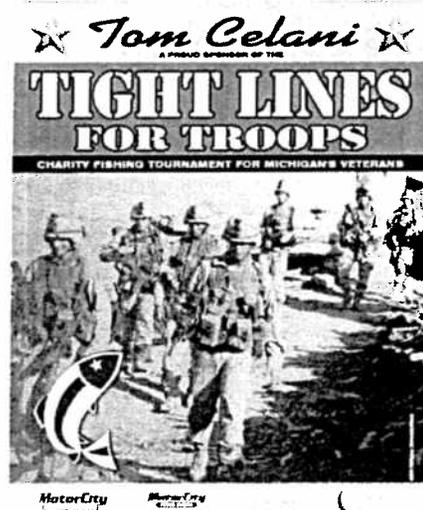


Rick Briggs: Director, "Invisible Wounds" National Campaign



TBI
*Invisible
Wounds*

OPERATIONNEVERFORGOTTEN.ORG



Remember!



Photographer: Unknown

No “Invisible Wound” is too mild to ignore or too severe to lose hope!

Thank you

Materials used in this presentation were adopted from:

- American Academy for the Certification of Brain Injury Specialists (AACBIS)
- Defense and Veterans Brain Injury Center
- The Clinical Neuropsychologist Publication - “Official Position of the Military TBI Task Force on the Role of Neuropsychology and Rehabilitation Psychology in the Evaluation, Management, and Research of Military Veterans with Traumatic Brain Injury”
- Manfred Tatzmann, Michigan Department of Community Health
- WASHINGTON, July 7, 2010 /PRNewswire-USNewswire
- Journal of Psychiatric Services 61:589-597, June 2010, American Psychiatric Association
- U.S. Department of Health and Human Services and Centers for Disease Control and Prevention

QUESTIONS



Items to Discuss

- Injured combatants issues:
 - * Current Michigan soldiers with TBIs
 - * ANAM for MANG
 - * Pending Purple Hearts for Michigan TBIs
 - * Joint Council position letter to Chairman of the Joint Chiefs of Staff on Tricare
 - * Veteran Identification on Drivers License

**STATEMENT OF MICHAEL F. DABBS, PRESIDENT,
BRAIN INJURY ASSOCIATION OF MICHIGAN TO SENATOR AKAKA AND THE
MEMBERS OF THE SENATE COMMITTEE ON VETERANS AFFAIRS – MAY 5, 2010**

Mr. DABBS. Good morning, and thank you, Senator Akaka, Senator Brown, and members of the staff of the Senate Committee on Veterans' Affairs, for the opportunity to address you about how effective State, local, and private entities have been engaged by the Veterans Administration to provide the best access to care and services for veterans with TBI.

The Brain Injury Association of Michigan was incorporated in 1981 as a 501(c)(3) nonprofit organization and is one of 44 chartered State affiliates of the Brain Injury Association of America. We are one of the leading State affiliates due to Michigan having more brain injury rehabilitation providers than any other State in the country. This extensive provider network has been developed over the past 37 years as a result of Michigan's auto no-fault insurance system. It provides a lifetime continuum of care with a singular focus: to assist the injured victim recover to their fullest potential.

My written testimony provides a comprehensive overview of our association: its veterans program under the guidance of Major Richard Briggs, Jr., U.S. Air Force (Retired), who is with me today; and the collaboration with the Michigan Department of Military and Veterans Affairs, the members of the Joint Veterans Council, the Veterans Service Organizations, the Michigan Association of County Veterans Counselors, and the Veterans Integrated Service Network 11 director and staff. As a result of this collaboration, I will share my observations, possible approaches, and potential solutions in response to the Committee's inquiry. My comments only reflect my experiences within the Michigan region of VISN-11, which is the lower peninsula of Michigan.

In Secretary Shinseki's report, he indicated a number of "landmark programs and initiatives that VA has implemented to provide world-class rehabilitation services for veterans and active-duty servicemembers with TBI." These are important developments, but let me express a few concerns. One, Enclosure A of his report, page 2, states that "VA directed medical facilities are to identify public and private entities within their catchment area that have expertise in neurobehavioral rehabilitation and recovery programs for TBI." To date, in Michigan there have been only three such referrals according to the VISN-11 Cooperative TBI Agreements Patient Tracking fiscal year 2009 report. One of these was due to a mother's insistence that such care be provided to her son.

This is a critical part of my testimony. I have provided a chart based on the information shown on the Commission on Accreditation of Rehabilitation Facilities, better known as CARF, Web site that indicates all accredited brain injury providers in the United States. This report indicates that in Michigan (correction) alone, there are nine brain injury residential rehabilitation providers with 78 facilities; that is 24 percent of the U.S. total. Eight brain injury home and community-based rehabilitation providers with 16 facilities; that is 33 percent. There are similar percentages for outpatient rehabilitation providers and vocational rehabilitation services.

There are even more non-CARF-accredited providers in Michigan, but, unfortunately, none of these providers or the CARF-accredited providers are being utilized to the extent they should be by the VA. I am going to provide the Committee with this book, which is our Directory of Facilities and Services in Michigan as a future reference.

[The aforementioned Directory was received and is being held in Committee files.]

Point 2, Enclosure A, page 2, of Secretary Shinseki's report, the second paragraph states the numbers and cost of veterans with TBI receiving inpatient and outpatient hospital care through public and private entities for fiscal year 2009. The average cost indicated is approximately \$5,800 per veteran. Let me give you a comparison.

As part of the Michigan Department of Community Health's TBI Grant from HRSA, Michigan's Medicaid data during the past 4 years indicates an annual average cost of \$28,500 just for services with a TBI diagnosis; and an annual average cost of \$41,200 for services with TBI and non-TBI diagnosis. I believe these numbers may be further indication of less than optimal use of outside contractors or, at the very least, not fully using these contractors and should be reviewed in greater depth.

Point 3, Enclosure A, page 4, number 4 discusses "Programs to maximize Veterans' independence, quality-of-life, and community integration, and establish an assisted living pilot." I would recommend to the VA that they immediately explore and/or expand such a pilot using the Michigan CARF-accredited providers. In fact, the soldier whose mother was insistent on the care outside of the VA system might be one to include in such a pilot. There are other concerns of equal importance that have been stated to us by the Michigan Department of Military and Veterans Affairs. I urge the Committee to review these as part of my report to you in terms of your future actions.

Again, let me thank the Committee for allowing me to testify. Brain injury is an unique injury that has by some been called a "life sentence" to veterans and to their families who do not receive timely—and I want to emphasize that word, "timely"—comprehensive, and sufficient cognitive rehabilitative care.

In wrapping up, let me personally testify to this fact. My father, who served with the U.S. Marines during the assault on Guadalcanal, sustained a brain injury that we learned about near the end of his life. His undiagnosed brain injury was diagnosed in the late 1970s, early 1980s as PTSD. The VA's treatment at that time was to overprescribe (my opinion) medication. It was not until there was a determination that there was a brain injury and the medication protocol was greatly changed did he ever have the quality-of life he should have had while raising his family.

On behalf of today's veterans, let me plead that we collectively do everything in our wisdom and power to prevent their lives having the same fate. Thank you.

[The prepared statement of Mr. Dabbs follows:]

PREPARED STATEMENT OF MICHAEL F. DABBS, PRESIDENT, BRAIN INJURY ASSOCIATION OF MICHIGAN TO SENATOR AKAKA AND THE MEMBERS OF THE SENATE COMMITTEE ON VETERANS AFFAIRS – MAY 5, 2010

Let me begin by expressing my sincere appreciation to Senator Akaka and all senators of the U.S. Senate Committee on Veteran Affairs for the opportunity to address you on the issue of our Association's experience in working with the VA to provide brain injury treatment and rehabilitation to veterans. As part of my testimony I will address how effectively state, local and private entities have been engaged by the VA to provide the best access to care and services for veterans with TBI.

Before discussing this matter, allow me to provide you with some basic information about the Brain Injury Association of Michigan and in particular, its Veterans Program. The Brain Injury Association of Michigan was incorporated in 1981 as a 501(c)(3) nonprofit organization by individuals with a brain injury, their families and professionals in the field of brain injury to provide support and education to one another, as well as to advocate on behalf of persons with a brain injury and their families. Additionally, research and prevention programs were primary goals. Our Association is one of 44 chartered state affiliates of the Brain Injury Association of America.

In 2007, with funding provided by the Health Resources Services Administration to the State of Michigan Department of Community Health (MDCH) as part of the Federal Government Traumatic Brain Injury State Grant program, a portion of these funds were sub-contracted to our

Association to serve the needs of Michigan veterans. Through the guidance of the MDCH's TBI Grant Services and Prevention Council the following goals were established:

- Goal 1—Create a comprehensive and coordinated state-wide Traumatic Brain Injury (TBI) awareness and resource program for veterans, their families and friends/co-workers through implementation of a Veteran TBI Awareness Campaign.
- Goal 2—Create a working relationship with the Michigan based VA VISN 11, VA medical centers and subordinate VA health care providers.
- Goal 3—Survey all TBI health care providers to ascertain their interest in and capabilities of providing care for military personnel.

In order to accomplish these goals, Major Richard Briggs, Jr., USAF (Retired) was hired to manage this program and accompanies me today. Though I would be pleased to share a more Comprehensive report about our Veterans Program accomplishments, I will limit my comments to addressing our activities as it relates to Goal 2 and its relevancy to the stated purpose of this hearing.

Major Briggs developed a working relationship with the Michigan Department of Military Affairs and with their assistance was able to create partnerships with the Veterans Service Organizations' Council and the VA County Counselors. Also, because of this relationship with the Department of Military Affairs, he and I were invited to meet with the Veterans Integrated Service Network (VISN) 11 director and staff. As a result of these meetings, Major Briggs was able to meet with the four VA Medical Center Directors in Michigan, as well as their respective OEF/OIF Coordinators. These meetings afforded Major Briggs the opportunity to share with them the unique capabilities for brain injury rehabilitation available in Michigan.

These capabilities will be explained at further length below as it pertains to the committee's inquiry. Finally, let me share with the Committee that the Brain Injury Association of Michigan's Veterans Program was just recently ranked 21st out of 128 nonprofits providing support and service to our veterans in a recently-conducted 2010 Veterans Choice Campaign special survey done by Great Nonprofits.

The information above is provided to serve as credible evidence of our ability to address the committee's meeting purpose and to demonstrate our efforts to reach out and work with the VA and the main organizations that already exist that work with the VA, or collaborate closely with it. It is my intention with the comments that follow to suggest to the Committee possible approaches or potential solutions to consider as it attempts to ensure that the intent of the Federal legislation is in fact carried forward at the local level. Let me be clear that my comments only reflect the experiences of our Association with VISN-11 and in particular, the Michigan region of VISN-11, which is the lower peninsula of Michigan.

In my nearly 18 years as president of the Brain Injury Association of Michigan, I have rarely seen as comprehensive a piece of legislation regarding brain injury and best practices as what was included in Title XVI, Wounded Warriors Matters of the "National Defense Authorization Act for Fiscal Year 2008." In addition, the Veterans Omnibus Health Services Act of 2010 (S. 1963) also is an excellent piece of legislation as it pertains to soldiers who have sustained a Traumatic Brain Injury (TBI). In fact, some of the proposed approaches that I will mention address some of the provisions (sections 506, 507, 509, and 515) of this bill.

In Secretary Shinseki's report to the Committee dated March 23, 2010 indicated a number of " " landmark programs and initiatives that VA has implemented to provide world class rehabilitation services for Veterans and active duty Servicemembers with TBI * * * " It is my opinion that these are valuable and important developments; but here are a few concerns I have regarding this.

1. The first point mentions " " * * 108 specialized rehabilitation sites across the VA medical centers that offer treatment by interdisciplinary teams of rehabilitation specialists * * * , _

I agree that the VA medical centers do offer such rehabilitation; however the VA appears to be limited in providing brain injury rehabilitation. Our experience in Michigan however, is that these hospitals are over-burdened and given their patient load simply are unable to provide timely care and frequency of care that is required for a person who has suffered a TBI. Furthermore, as we have witnessed with one of the four VA medical centers in Michigan that is located in close proximity to a major hospital medical school, this VA medical center only has one doctor who is qualified to administer Neuro-psychological testing. Neuro-psychological testing is critical to the proper and thorough screening of soldiers who have a suspected TBI.

As further evidence of the significance of this problem, let me provide you with one of the recommendations given to me by the State of Michigan Department of Military Affairs in preparation for this testimony: “Access problems and long waits continue to be problematic despite the best attempts of the VA.”

One additional point to consider regarding this issue of adequacy of resources— it is my understanding that Michigan has over 725,000 Veterans, and only 207,000 are registered with the VA. Yet as stated above, the current VA medical centers are seriously over-whelmed with trying to provide care to those they are servicing. Assuming the Michigan numbers of Veterans and the Veterans who are registered with the VA are reflective of other states, this would dictate that the VA absolutely must aggressively seek outside contractors to assist them with providing care to our Veterans. Simply put, the VA must use its financial resources to contract with public and private partners to provide care and not spend these funds trying to build facilities and staff them. I implore this Committee and the VA to immediately take action on this issue. Veterans who have a TBI need treatment now—not in a few years when a few more facilities might be operational. Does it even seem reasonable to think that there are sufficient funds to build enough facilities in Michigan to meet the long-term care needs of Veterans with TBI, if the numbers above are correct; much less the rest of U.S.?

2. The second point indicates that “TBI screening and evaluation program to ensure that Veterans with TBI are identified and receive appropriate treatment for their conditions” —though this has been implemented, the current assessment that I believe is being referred to—a four question survey—is not adequate. Another one of the State of Michigan Department of Military Affairs recommendations states: “TBI continues to be missed when it co-occurs with other disorders. Soldiers who are being diagnosed with disorders such as Bipolar Disorder and PTSD should be universally screened for TBI because of the similarities in their presentation. Likewise all soldier receiving VA disability for hearing loss or Tinnitus (ear ringing) should have mandated TBI screen.”

3. Enclosure A, Page 2 notes that “* * * VA directed medical facilities to identify public and private entities within their catchment area that have expertise in neurobehavioral rehabilitation and recovery programs for TBI, and to ensure that referrals for services are made seamlessly when necessary.” A similar point is made in S. 1963, Section 507. To date in Michigan, there have been only three such referrals according to the VISN-11 Cooperative TBI Agreements Patient Tracking FY 2009. One of these was due to a mother’s insistence that such care be provided to her son.

This is a critical point of my testimony. For over 37 years, Michigan, due to its unique automobile no-fault insurance system, provides comprehensive lifetime care for those sustaining injuries in an automobile crash in Michigan. The care provided is unique to each person and provides cognitive rehabilitation care. As a result, there are more brain injury rehabilitation providers than any other state in the U.S.I have provided a chart that we created as an attachment to this testimony. This information was taken directly from the Commission on Accreditation of Rehabilitation Facilities (CARF) Web site that indicates all certified brain injury providers in the United States. Let me give you just a couple of the more salient points. There are 9 brain injury residential rehabilitation providers with 78 facilities in Michigan— this is 24% of the total in the

U.S. Michigan has 8 brain injury home and community-based rehabilitation providers with 16 facilities in Michigan—this is 33% of the total in the U.S. Brain Injury outpatient rehabilitation providers in Michigan number 12 with 22 facilities, which represent 15% of similar providers in the Nation.

And finally, there are six providers with 12 facilities, which is 24% of the total in the U.S. Again, these are CARF accredited providers and represent only a fraction of similar program providers within Michigan who are not certified. A copy of the Brain Injury Association of Michigan's Directory of Facilities and Services will be provided to the Committee's staff to provide you with an idea of just how extensive these resources are throughout Michigan. All of these providers are spread across Michigan, though the preponderance are located in or near the larger urban areas of the state. Attached is a Michigan map with just the CARF accredited facilities.

4. Enclosure A, page 2, second paragraph also states the numbers of Veterans with TBI receiving inpatient and outpatient hospital care through public and private entities for FY 2009. The average cost per Veteran would be \$5,800. By way of comparison, as part of the MDCH TBI Grant from HRSA, Michigan has done an extensive analysis of its Medicaid Data for the past 10 years. During the past four years, our analysis of a subset of TBI cases who receive Medicaid provide us a the cleanest estimate of cost (that is, Medicaid cases who had no other insurance, were not in Medicaid prior to their TBI hospitalization, had Medicaid eligibility for at least a year after the TBI hospitalization and had Fee For Service cost data) showed the following:

- > Annual average cost of \$28,539 just for services with a TBI diagnosis.
- > Annual average cost of \$41,243 for services with TBI and non-TBI diagnosis.

An issue to consider regarding this data is that I believe that Medicaid is more restrictive of services than would be available through the VA.

5. Enclosure A, page 4, #4 discusses "Programs to maximize Veterans' independence, quality of life, and community integration, and establish an assisted living pilot." I believe this program could have been expedited had the VA utilized the resources available in Michigan. I would encourage the Committee to recommend to the VA that they immediately explore and/or expand such a pilot utilizing the CARF accredited providers that I have mentioned above. In fact, the soldier mentioned above whose mother was insistent on the care outside of the VA system might be one to include in such a pilot.

RECOMMENDATIONS - The Brain Injury Association of Michigan would readily welcome the opportunity to partner with the Veterans Administration to work expeditiously to implement the policy directives and guidance that Congress and the VA have directed. With the collaboration of the partners that I indicated in the beginning of this testimony, I believe that we can effectively assist with demonstrating how the "new" VA can operate in the 21st Century to meet its congressionally mandated responsibility of providing care to our Nation's Veterans.

1. Create a pilot study in Michigan that utilizes the extensive continuum of care of CARF accredited brain injury rehabilitation providers. The goal of such a pilot would be to validate Secretary Shinseki's desire for a seamless system of care between VA and private or public partners. Additionally, its greatest value would be to ensure the Veteran is receiving the most comprehensive program of brain injury rehabilitation that would give them the greatest opportunity to reintegrate into the community.

2. Review current legislation and possibly creating additional legislation as required creating a program that would address some of the following concerns (this is not comprehensive, simply a starting point):

- Automatically enroll a soldier into the VA upon discharge from active duty;
- Improved TBI screening;
- Comprehensive case-management;

- Increased educational offerings and support regarding their loved-ones who have a TBI pertaining to their challenges and limitations;
 - Realization of “seamless transitions” and an interdisciplinary approach between health care providers across disciplines to assure that the Veterans challenges is not navigation through bureaucracy or red tape.
3. The VA should undertake a study of medical specialties that they have shortages of and what opportunities exist in their region to ensure that more timely care is rendered to Veterans who have sustained a TBI.

CONCLUSION - In conclusion, let me again express my sincere thanks to the Committee for allowing me to testify. Brain injury is an unique injury that can be a ‘life-sentence’ as one radio personality once called it. It can be a needless life-sentence to the Veteran who does not receive timely, comprehensive and sufficient rehabilitative care. I would also suggest that it is a life-sentence for their loved ones. It impacts the family and the community. I can personally testify to this fact as my father who served with the U.S. Marines during the assault on Guadalcanal sustained a brain injury that we learned about near the end of his life. His undiagnosed brain injury was diagnosed in the late 1970’s, early 1980’s as PTSD. The VA’s treatment at the time was to over-prescribe (my opinion) medication. It wasn’t until there was a determination that there was brain injury and the medication protocol was greatly changed did he ever have the quality of life; he should have had while raising his family. On behalf of today’s Veterans let me plead that we collectively do everything in our wisdom and power to prevent their lives having the same fate. Attachments:

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY SENATOR DANIEL K. AKAKA TO MICHAEL F. DABBS, PRESIDENT, BRAIN INJURY ASSOCIATION OF MICHIGAN

Question 1. You stated that you have concerns with the current TBI screening tool. Concerns have also been expressed about the clinical validity of this tool. Please specifically identify your reservations in addition to possible ways to improve the tool.

Response. I do not have expert knowledge or training regarding TBI screening tools for me to be able to provide specific concerns or more importantly about how it can be improved. However, let me share these observations regarding the current tool (I am referring to the VA’s TBI Pre-screening Tool—four questions evaluation tool). First, it does not require much experience or knowledge to recognize that these limited and broad questions are inadequate at best. These questions would appear to disproportionately identify the number of soldiers, which may lead to unnecessarily overloading the medical systems of the DOD and VA.

Second, though it may not be intended by the military command, we have heard many anecdotal comments from soldiers who believed responding affirmatively to any of the questions on this tool would jeopardize their career. I have no potential solutions regarding this; however, this may be one of the most difficult and pressing issues requiring attention.

Third, it is puzzling as to why this tool was developed when there has been a great deal of research into various concussion tools. I certainly do not know all of the details in the development of this tool and at this point it is meaningless to discuss; other than to realize that in the future, greater effort should be made to seek out and use the state-of-the-art resources available and expend the effort to improve them.

Fourth, as directed by the 2008 National Defense Authorization Act for pre and post-deployment testing, as well as in the combat theater testing, this directive does not appear to have been applied, or at least not fully to National Guard soldiers—as indicated by experiences in Michigan. This would create problems for soldiers, whose brain injury is not addressed as quickly

as possible that could lead to problems with their family, holding a job, substance abuse and others. Additionally, it further exacerbates issues with the soldier that the VA must contend with.

Question 2. Cooperation with the private sector is important to expand access to care. However, veterans are a unique population. What steps has your organization, or other private entities with which you may be familiar, taken to become more “culturally literate” with respect to servicemembers and veterans?

Response. In the first sentence, it is stated that “Cooperation with the private sector is important * * *” with which I totally agree. Unfortunately, as I indicated in my testimony this has not been borne out by execution of this policy. Michigan’s wealth of TBI rehabilitation continuum of care services has not been effectively used despite the relationships we have established with VISN-11 and the four VA medical centers. Furthermore, I believe in the testimony that I witnessed at the hearing that indicated that the VA was going to have a pilot of less than 12 veterans using services is an embarrassment. Such a limited number when compared to the thousands requiring services should be seen as unacceptable. In my judgment, if there were 12 sent to Michigan rehab facilities, I would see it as unacceptable. Furthermore, why is it that a pilot is only now being done—nearly 10 years since the start of the conflict?

The poly-trauma system that was created, I believe was an excellent, well-conceived approach to dealing with brain injuries and other trauma. What has not been dealt with effectively is the long-term rehabilitative care necessary. Appointments at a VA Medical Center every couple of months (or even longer) is woefully inadequate to providing cognitive rehabilitation. Again, let me urge that the over 35 year history of brain injury rehabilitation and expansive network of care in Michigan be utilized, to demonstrate what can be done in assisting a soldier recover.

In regards to our Association’s being “cultural literate” it is for this very reason why Richard Briggs, Major, USAF (Retired) was hired. As a former U.S. Army Captain, I was keenly aware of the need to hire an individual with a military background to work on this issue. It was clear to me that the individual managing the Association’s efforts with veterans must understand the chain of command, military terminology, and be able to relate to those in the military. Unfortunately as mentioned above, there has been nearly no interaction with other private facilities by the VA in the State of Michigan; thus, the military literacy issue has not been an issue to date. However, we completely agree that this will be a key component in the development of any relationships. We pledge our efforts to ensure that any such facility receives training about the military culture to ensure they can provide effective rehabilitation.

Finally, Major Briggs has worked with numerous public and private entities on recreational activities for soldiers. As part of those efforts, Major Briggs has ensured that there is an understanding and respect for the military culture, which has won him many words of praise from participants. Most notable was a comment following a recent fishing event from a Viet Nam era veteran who commented that seeing all of the American and Service flags flying along the pier, as well as people cheering and waving made him feel that for the first time since he returned from Viet Nam, he was finally welcomed home!

Question 3. Does your organization, or others with which you are familiar, use tele-health technologies to provide care and services to individuals with TBI?

Response. Our Association has not utilized nor has there been a need for telehealth technologies. However, because of comments we have received from many of the soldiers who desire support but do not wish that support to be in a typical support group environment, we will be introducing in the third quarter of the calendar year a telephonic support group. This will enable a veteran to remain in their home (without the need to travel) and know that at a prescribed time they can meet with other veterans via phone (possibly video in the future) to receive support and provide support.

Included with my response, I am including an outline of the TBI Resource Optimization

Center's Brain Injury Navigator, which is being piloted at the current time. As shown, the purpose is to assist a soldier or their family with identifying needed services in or near where they live.

CONCLUSION - Once again, I deeply appreciate the opportunity to address the U.S. Senate Committee on Veterans Affairs and to respond to these questions. Senator Akaka asked a very significant question during the Question and Answer period at the Hearing, which I did not feel I responded to in an adequate manner. In essence, the question was, is the VA doing a more effective job treating brain injury today than they were two or three years ago. In considering this question during the past few weeks, I would respond that Congress has enacted cutting edge laws and guidance to address the needs of veterans with a Traumatic Brain Injury. Thus, there has been an effort made to improve care—or, said another way, when there was effectively nothing to begin with, anything is better.

However, the execution of these laws and policies remains less than adequate and therein is the problem that is creating the distrust, mistrust and futility being experienced by many veterans. The VA so jealously guards its Congressional mandated responsibility to care for our veterans; however, the sheer numbers of veterans and the limited number of VA medical facilities simply prohibit the VA from being able to carry out this responsibility properly or fully. I do not believe that adequate funds can be appropriated to the VA to build the needed facilities, staff them and operate them. Furthermore, it is highly unlikely there can ever be sufficient facilities so as to make them convenient to where veterans live. Thus, a new paradigm must be used—namely contracting with private providers and the VA effectively monitoring the delivery of care.

Finally, allow me to reiterate my comment pertaining to TRICARE and its rules, which effectively sets up the VA to not be as effective as it could be in treating a veteran with a brain injury. It is my understanding that TRICARE currently operates using Medicare rules. Medicare rules do not address cognitive rehabilitation or long-term rehabilitative care and yet this is the essence to the continuum of care needs of the veteran. Because cognitive rehabilitation is not provided immediately following the time of injury, once the soldier leaves the active military and must use the VA system, significant time has elapsed. This dramatically decreases the opportunity for the soldier to recover skills both cognitively and emotionally that may have been impaired by their Traumatic Brain Injury.

Changing the Medicare Rules to expand coverage to cognitive rehabilitation could be one of the quickest and most effective changes to providing comprehensive brain injury rehabilitation to soldiers, which would give them a greater opportunity to return to the quality of life they enjoyed prior to their military duty. I believe it would also lessen the demands for brain injury rehabilitation on the VA system.